EXHIBIT E - PART 6

Q. Have you ever seen the first two pages of the inmate medical intake record pertaining to Spencer, which we have marked as Exhibit 7?

A. I've seen it at the deposition and I believe -- I believe this was sent forward with -- to the Commission of Correction.

Q. Take a look, if you would, at the second page and on the bottom, number 25, it refers to illegal drug use.

A. Yes.

Q. Then there's a note 24 hours heroin.

A. Yes.

Q. Above that it says rehab, yes, six months ago. You see that?

A. Yes.

Q. Above that, number 21, hospital, it says detox Putnam Hospital six months ago.

A. Yes.

Q. There's no indication on this form that he was asked anything about how he used heroin; is that correct?

A. From this form I can't see it on

the form.

Q. There's no indication on this form as to anything pertaining to what effects he had the last time he detoxed, namely six months ago at Putnam Hospital, correct?

A. Yes.

Q. And there's no indication on this form of any observations of his skin to see, for example, if he had needle marks or anything along those lines, correct?

A. Yes.

Q. Did you ever ask anybody why it was that Spencer wasn't asked the questions that are listed specifically in AmeriCor's policy that, again, references this National Commission standard?

MR. KLEINBERG: Objection.

MR. COON: Objection.

MR. RANDAZZO: Objection.

A. This form was completed by Correction Officer Vasaturo. I don't know what questions were asked of Spencer by the nurse on duty. It's not indicated -- to answer your question specifically, it's not indicated on

this form.

Q. Did you ever do anything to find out what the nurse on duty did by way of the receiving screening in terms of Spencer?

A. In terms of Spencer but broader than Spencer obviously, beyond Spencer, is to invite the National Institute of Corrections to come in and help us evaluate where we go. But specifically on this form this question, no.

Q. How about the nursing staff in general, regardless of the form, did you ever inquire either through Duffy or somebody else as to whether they performed the receiving screening that's indicated in their policy, pages 421 to 422, and part of the National Commission standard?

A. We had a number of conversations at MAC meetings about suicide, about -- or even following MAC meetings. But I don't specifically have a recollection of the content of a specific conversation. I don't.

Q. Do you recall any conversations, regardless of whether it was a MAC meeting or not, about whether or not AmeriCor staff

complied with policy number 131, which is the National Commission standard according to Bates stamp 421 to 422?

A. I don't recall.

Q. Flip, if you would, to 448, which is the suicide prevention policy, three pages in length.

A. *(Perusing document.)* Okay, I read it.

Q. Before I get to that, I'm sorry, I just want to go back for a minute to what we were just discussing in terms of the initial intake of Spencer and whether or not the nursing staff asked the questions that were indicated on pages 421 to 422.

And I'm going to show you the final report on the death of Spencer which was done by the Commission. It was marked as Exhibit 12, paragraph 9. Okay?

A. Okay.

Q. Correct me if I am wrong, but that paragraph indicates that the intake nurse's assessment of Sinkov was inadequate?

A. That is correct.

Q. It also indicates that although Sinkov was not displaying active signs and symptoms of withdrawal at the time of admission, his reported history of recent heroin use warranted more detailed attention than was provided. You see that?

A. Yes.

Q. It also indicated that the physical exam did not comport with the minimum standards, correct?

A. That's what it says.

Q. Did you have any follow-up discussions with Duffy or anybody else at AmeriCor with respect to intake assessments being performed by the nurses other than the recording of vital signs?

A. I specifically remember the vital signs. But I believe any conversation I would have had would have been on the issues involved. But as I sit here, I cannot remember the specifics of the conversation, except I do remember -- I do remember the vital signs, because that was a directive that came out of that, that I wanted the vital signs taken.

Q. You don't recall anything else about any detailed questions that should have been asked of Spencer based on his reported use of heroin?

MR. COON: Objection to the form.

A. Like I said, I've had many conversations with Mr. Duffy, but as I sit here today, I cannot remember specifics of the conversations except that one point.

Q. Back to the suicide prevention policy that's pages 448 to 450. On the first page it says that "Inmates will be evaluated for potential risk of suicide during the intake process." You see that sentence?

A. Yes.

Q. The next sentence, "Inmates determined to be at risk as a result of the screening process will be placed on suicide precautions and immediately referred to the psychiatrist." Do you see that?

A. Yes.

Q. Did you understand that that was an obligation of both the nursing staff and the

correction staff as part of this team approach?

MR. COON: Objection.

A. Well, the screening process needs to be done right in the first place and then the referrals need to be done, absolutely.

Q. But both the nursing staff and the correction staff had the obligation of determining whether an inmate was at risk and referring them to a psychiatrist?

MR. COON: Objection.

A. I believe the correction staff has the obligation to do the suicide screening. The follow up is -- the follow up is done by AmeriCor. And obviously, you know, I leave it to Mr. Duffy to develop his internal policy, what he holds his people accountable for. I hold him accountable to the National Commission on Correctional Health Care standard. He references the standard, but as I sit here, I don't know what the standard requires versus what he has in the policy.

Q. Did you ever check into that?

A. Not that I can recall.

Q. In terms of that sentence that I

just read, "Inmates determined to be at risk as a result of the screening process will be placed on suicide precautions," did you ever speak with Duffy as to what was meant by the term suicide precautions?

A. I don't -- I don't recall -- I don't recall reviewing this manual or seeing this manual, so I don't recall any conversations with Mr. Duffy.

Q. Take a look, if you would, at the next page, 449, top. "Inmates who are placed on suicide precaution," same term, "will be placed in the facility's mental health unit or placed on regular observation status such that they are subject to monitoring by correctional and/or health care personnel, monitoring should occur every 15 minutes while the inmate is on suicide precaution." You see that?

A. I do.

Q. Do you know if that's consistent with the National Commission standard?

A. I don't know if Mr. Duffy is referring to the medical staff, but certainly it doesn't meet the standard of our correctional

staff. Because a 15-minute -- a 15-minute monitoring by correctional staff, it would be a -- require a constant supervision. So I don't know whether he's referring to the medical staff. You know, I don't want to speculate on what he intended in his language there.

Q. Did you ever speak with him about what he intended in this language?

A. Not that I can recall.

Q. Or what he communicated through the chain of command or otherwise to the nursing staff as to whether a 15-minute or constant watch should be implemented?

A. I don't recall reviewing this document with him at all.

Q. Take a look, if you would -- let me just back up. Did you ever speak with Duffy about what he communicated to his staff regarding 15-minute or constant watch in terms of a suicide precaution?

A. Not that I could recall.

Q. Page 448, again which references this National Commission standard, says that "Training for health care personnel will occur

annually." You see that?

A. Yes.

Q. And the training that's referenced there is specifically "training to recognize verbal and behavioral cues that are indicators of suicide risk and how to respond appropriately." You see that?

A. That's correct.

Q. And the jail was accredited in 2004?

A. As I recall, the accreditation may -- if you recall, I didn't have a specific recollection on the exact time. I believe the process was started in 2004 and it might have been completed in 2004, it might have gone into 2005. We can get you that information, when it was accredited, but I don't have a recollection exactly.

Q. At the time it was accredited by the National Commission training in fact had not been provided to health care personnel; is that correct?

A. I don't know what training he's referring to here. The training that I was

referring to earlier I believe was suicide screening training, you know; in other words, the same that the correction officers get. This training may be internal training to him. I don't know what he intended.

Q. Did you ever ask prior to the training in November of '06 being given to health care personnel if AmeriCor staff received any training in the area of suicide at all?

A. I don't recall. I know they received some training, but I don't specifically know what training he conducted.

Q. Part of the investigatory process involving the death of Spencer included members of the sheriff's department conducting an investigation, correct?

A. Yes.

Q. Did you ever receive any information or feedback with respect to that investigation?

A. The feedback -- the feedback that I recall -- that was a criminal investigation. When you have a death, an unattended death in the community or a death in the jail, you have a

criminal investigation. That was a criminal investigation. And there was no criminality identified, as I recall. And all the information from -- I believe from that investigation, plus all the reports, were forwarded to the Commission for their investigation.

Q. In terms of the finding that there was no criminality, how did you find that out?

A. I believe just verbally when the investigation was completed.

Q. Who conveyed that to you?

A. I don't recall.

Q. Did you ever see any of the underlying investigatory documents, statements that were taken, notes, anything else?

A. They were part of the packet that went to the New York State Commission of Correction. I reviewed -- I believe I reviewed everything before it went up, as I recall.

Q. Do you recall if you reviewed, for example, the sworn statements that the correction staff gave to the investigators?

A. I believe I reviewed the packet

before it went up, which I believe I would have read everything. But as I sit here, I can't specifically remember.

Q. Let me show you, for example, Exhibit 11, which is Vasaturo's sworn statement. Do you remember if you ever saw that before today?

A. I believe I did, but I don't have a specific recollection of, you know, when I looked at it, when I reviewed it.

Q. Do you recall as you sit here today, reviewing any of the other statements that were given?

A. I believe I did.

Q. But you don't have a definite recollection, though?

A. Because at the time I was trying to find out all the information that I could. But as I sit here this many months gone by, I don't specifically remember that I picked up this statement and read it. But I was, you know, sending stuff to the Commission and I would normally review everything that would go out to the Commission.

Q. Prior to Spencer's suicide there was another suicide in the jail by an inmate named Rivera?

A. Yes.

Q. You were the sheriff at the time, correct?

A. Yes, I was.

Q. Do you recall that there was also an attempted suicide under your tenure?

A. I believe we have had two attempted suicides. I believe one was an inmate drinking water, trying to drink water. And the other one, I don't remember the specific date, but it was -- I believe it was an attempted suicide where he was rescued.

Q. And the one who was rescued was Rodriguez?

A. I believe that's who it was.

Q. Do you recall the method of attempt?

A. One was by drinking water and one was I think trying to use hanging, which is the most common.

Q. Do you know if Rodriguez was under

any type of routine or heightened level of supervision?

A. I don't recall.

Q. How about the inmate who drank the water, do you recall if he or she was under any heightened level of supervision?

A. I believe there was a point in time when he was put on, because we figured out what he was trying to do. It was a very unusual method of trying to commit suicide. But I believe once we determined what he was doing he was put on constant, as I recall.

Q. Do you know if in Rodriguez' case he was screened using the form at that time, the suicide screening prevention form?

A. I don't recall.

Q. You don't recall anything about his score on that form?

A. I don't recall.

Q. How about the inmate who was drinking water, do you recall the score on that individual's form?

A. I don't recall.

Q. Was the Commission notified of the

attempted suicides?

A. I believe so, yes.

Q. Is that required?

A. Yes.

Q. Do you know if they did any investigation?

A. I don't recall if they came down or if it was done, you know, through the mail, I don't recall.

Q. Do you recall if there were any outcomes, reports or anything generated by the Commission in connection with those two attempts?

A. Not that I can recall.

Q. In terms of Rivera, do you recall that he had a history of heroin use?

A. Yes, I recall that.

Q. Do you recall that he, like Spencer, was on a 15-minute watch?

A. I believe he was on -- I believe he had a six in the suicide screening.

Q. But he was on a 15-minute watch, correct?

A. I believe he was.

Q. And he was going through a program which involved detoxing from heroin, correct?

A. Yes.

Q. And part of that included the administration of medications?

A. I believe so, yes.

Q. He was not on a constant watch despite the fact that he was actively going through withdrawal, correct?

MR. KLEINBERG: Objection.

A. As I recall -- as I recall, he was -- he was on 15-minute supervision.

Q. But he was not on a constant watch?

A. As I recall, he was not.

Q. He was also in North Housing Unit One?

A. As I recall, he was in North Housing Unit One, yes.

Q. That's where Spencer was too, right?

A. Yes.

Q. He also committed suicide by hanging from his sweat shirt?

A. Yes.

Q. Did you ever see the Commission's report on Rivera?

A. Yes.

Q. Take a look, if you would, at Exhibit 14, specifically paragraph 19 which is on page 5. It refers to the North Housing area post and the duties of that post assignment, correct?

A. Yes.

Q. It specifically says that "In addition to supervising the North Housing Unit, the officer on that post also has the responsibilities to supervise a program area down the hall, movement into the adjacent recreation yard and a separate four-cell housing unit approximately 100 feet away." Do you see that?

A. Yes.

Q. Since the time that this report was issued on January 11th, 2005 have any of those responsibilities been modified?

A. Yes.

Q. In what way?

A. The four-cell housing unit is no

longer used except for constant watches, which would not involve the North Housing Unit officer.

Q. Any other --

A. And we have put in for a -- we requested a staffing analysis and we obtained a program officer post five days a week when most of the activity takes place. On the weekends, the program rooms are very close to the North Housing Unit and there's not a problem for that officer to monitor inmates in with programs that are taking place. There aren't that many on the weekend, primarily a Saturday bible study.

Q. Prior to January 11, 2005 the four-cell housing unit, was that used all the time or is that something that the NHU post had only from time to time?

A. That was from time to time, as I recall.

Q. In terms of the other responsibilities noted in this report, the North Housing Unit officer is still required to supervise the program area and the recreation yard on nights and weekends when the program

officer is not there, is that fair to say?

A. That's fair to say. And that is -- that still is the -- is the case after the staffing analysis. As I said earlier, the Commission has looked at all aspects of our operation when they do the staffing analysis. It's quite a detailed document.

Q. Did you ever come to learn at any point in time that prior to Spencer's suicide, in fact, during the period of time between the 15-minute checks that were being performed the North Housing Unit officer who was responsible for the 15-minute checks had to take a group of inmates for bible study?

A. I believe -- I believe the bible study inmates were brought to him, the housing officer, right at where his post is. I mean, the program room is right near -- is right near the North Housing Unit.

Q. But you were aware of that prior to today?

A. Prior to today that that would happen on weekends?

Q. No, that that happened specifically

at the date and time that Spencer committed suicide?

MR. KLEINBERG: Objection.

A. I believe I've picked that up in the depositions and I don't recall if I picked it up prior to that.

Q. You don't recall prior to the depositions in this case having any information come across your desk about the North Housing Unit post having to cover the bible study within the 15-minute period of checking on Spencer?

A. I know -- I know that the North Housing Unit, and even after the Commission of Correction has done their staffing analysis, that is still the case on weekends. And I may have read it in a report that came across my desk, Miss Berg, but I don't specifically -- specifically remember that fact. It may even be in the final report, I don't recall.

Q. On the date of Spencer's death - May 20th, 2006 - was the North Housing Unit officer responsible for movement into the adjacent recreation yard?

A. For the inmates from North Housing,

and the recreation yard is right there near his post.

Q. And at the time that this report was issued on Rivera in January of 2005 the program location and the recreation yard location have remained the same, correct?

A. Yes.

Q. In other words, back in '05 when they issued this report the program area was adjacent to the post for the North Housing Unit officer, correct?

A. Yes.

Q. And the recreation yard was right there as well?

A. Yes.

Q. Under those circumstances, the final report on Rivera still says, "The additional duties added to this post prevents an officer from being able to maintain active supervision adequately." You see that? Paragraph 19.

MR. KLEINBERG: There's more to that sentence.

Q. "And should be reviewed as part of

an updated staffing analysis." Do you see that?

A. Which was done.

Q. But the report nonetheless still says that "The additional duties added to this post prevented the North Housing Unit officer from being able to maintain active supervision adequately," correct?

A. That's a statement they made in this report. But they have since come back and done a full staffing analysis.

Q. Is that in writing?

A. The staffing analysis is in writing, yes.

Q. Does the staffing analysis that you received from the Commission in writing say anything specifically about the weekends or night duties of the North Housing Unit officer covering the programs and the recreation yard?

A. It specifically provides the staffing for that time period. And the people conducting the staffing analysis totally review the operations of the facility, so they understand the number of inmates, the activities that are taking place. And as I said, we

requested the staffing analysis, the staffing analysis was conducted. And as I said, as we sit here today the program officer position is a Monday through Friday position based on -- based on the requirements from the Commission.

Q. Did the Commission ever tell you in words or in substance that it was, contrary to this report, acceptable for the North Housing Unit officer to both supervise the program area and the adjacent recreation yard in addition to normal duties?

A. The Commission -- the Commission is not going to come tell you specifically what you can do or what you can't do. They work on manpower equivalents in their analysis and relief factor. And we rely on the wisdom of the Commission in doing the staffing analysis.

Q. So they never told you that it was acceptable for the North Housing Unit to continue having program area responsibilities and recreation yard responsibilities on nights or weekends?

A. They would never specifically come out and say something like that.

Q. But they never did is my question?

A. No, they never did. But they were fully informed of all aspects of the operation of the correctional facility.

Q. By who?

A. The jail staff.

Q. Who?

A. When -- when --

Q. Who, who is the jail staff, name them?

A. Captain LeFever is probably the primary person they talk to when they do a staffing analysis.

Q. And how do you know as you sit here today that Captain LeFever fully apprised the Commission of anything? How do you know that, were you there?

A. Miss Berg, I wasn't there, but I'm just telling you --

Q. So how do you know?

A. I just know how they operate. They review the entire facility, they talk to correction officers.

Q. How do you know what LeFever

communicated to them, if anything?

A. I wasn't there, Miss Berg.

Q. Take a look, if you would, at Exhibit 14, the recommendations for the Sheriff of Putnam County. Number one, "The sheriff should question the housing area officer for the North Housing area for the accuracy of his documented times he completed rounds." Do you see that?

A. Yes.

Q. Do you recall that as a result of Rivera's death it was learned that staff was rounding off times in the log book?

A. Yes.

Q. Do you recall that the housing area officer referenced in a report on Rivera was Vasaturo?

A. Yes.

Q. Did you ever question him?

A. We changed the policy, because we felt like it was not just a one-person issue, it was a systemic issue. So the policy was changed to ensure that rounding was no longer accepted, to make sure that everyone knew that rounding

was not accepted.

Q. Did you direct somebody to change that policy?

A. Captain LeFever.

Q. Do you know if he in fact did it?

A. Yes, he did.

Q. Was it a policy or procedure that was changed?

A. I believe it was a procedure.

Q. Was the procedure a different form of Exhibit 18, in other words, a previous edition?

A. I don't recall.

Q. Did you ever see the procedure that was changed?

A. No, all I knew is that he changed the procedure.

Q. Did you ever see Exhibit 40, which is a memo from Convery to LeFever about the Commission's recommendations on the death of Rivera?

A. I remember seeing this in the depositions. I don't recall seeing it prior to the depositions, but I may have.

Q. Did you ever see Exhibit 13, which was LeFever's response?

A. I recall seeing it, of course, in the depositions. And I may have seen it back then, but I don't have a specific memory of seeing the document.

Q. This document refers to in paragraph two, "The correction officer on duty during the incident was counseled regarding his rounding of the times of his security checks." Do you see that?

A. Yes.

Q. Do you recall independent of this, meaning not what I just read, but do you have a memory as you sit here today that Vasaturo was counseled with respect to rounding off the times?

A. I don't -- I don't have a recollection of it. But as I said earlier, I have a great undersheriff, I got a great staff. And by the way, just so you know, when the word -- when the word sheriff is used in many documents it refers to the office of the sheriff, not specifically that the sheriff would

individually do every action himself. I think that's an important distinction.

Q. Well, we know you didn't verbally counsel or in any way counsel Vasaturo, correct?

A. Right.

Q. Do you have a recollection of receiving information from somebody that that occurred?

A. Like I say, the document -- I remember the document from the deposition. This was, you know, three and a half years ago. I don't have a specific memory. But I talk to Undersheriff Convery about many things every day and I talk to Captain LeFever about many things every day. I just don't specifically have a recollection of it.

MS. BERG: Let me have marked as 47 a copy of an October 29, 2004 letter from Sheriff Smith to Commissioner Lamy with respect to the Rivera report.

(Whereupon, Letter, 10/29/04, was marked Plaintiff's Exhibit 47 for identification.)

A. *(Perusing document.)* Okay.

Q. You've read Exhibit 47?

A. Yes, I have.

Q. On the second page, first numbered paragraph refers to the suicide screening policies and procedures.

A. Right.

Q. The last sentence of that paragraph, "Immediately after the incident the department inspector general conducted a special inspection to ensure that suicide screening procedures were in compliance with current directives." Do you see that?

A. Yes.

Q. Do you have a recollection of that occurring as you sit here today?

A. I don't have a recollection of it. But as I said, I task the IG to do many things. And obviously if I said it, it happened.

Q. At this time it was Perry?

A. Yes.

Q. Did you ever receive anything in writing from him regarding that special inspection?

A. I don't recall.